| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155005 | A. BUILDING _____ B. WING _____ | R-C 01/12/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MANORCARE HEALTH SERVICES | 1345 N MADISON AVE ANDERSON, IN 46011 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS | {F 000} | | |

This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00160017 and IN00160549.

This visit was done in conjunction with the Investigation of Complaint IN00161048.

Complaint IN00160017 - Corrected

Complaint IN00160549 - Corrected

Survey dates: January 9 and 12, 2015

Facility number: 000005
Provider number: 155005
AIM number: 100270840

Surveyor:
Betty Retherford RN

Census bed type:
SNF/NF: 129
SNF: 25
Total: 154

Census payor type:
Medicare: 18
Medicaid: 100
Other: 36
Total: 154

Sample: 4

Manorcare Health Services was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the PSR to the Investigation of Complaint IN00160017 and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155005 | A. BUILDING _____ B. WING _____ | R-C 01/12/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MANORCARE HEALTH SERVICES** | **1345 N MADISON AVE ANDERSON, IN 46011** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | Continued From page 1<br>Complaint IN00160549.<br><br>Quality review completed by Debora Barth, RN. | {F 000} | | |